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ABSTRACT

The author looks at some of the assumptions underlying staff development programs, examines some existing formats, and suggests ways to heighten the value of investments in staff development, particulary at mid-career. Two programs are emphasized--the Mid Career Program in Educational Administration, which is for experienced administrators, and the National Program for Educational Leadership, which is for persons interested in entering educational administration. Whatever the program, it must deal with the problem of acquiring knowledge and utilizing it--or, bridging the gap between theory and practice. The approach stressed here, clinical education, is defined as the process of learning in field settings where the sustaining emphasis is knowledge application, feedback, appraisal, and reapplication directly to affect improvements in human performance. Two essential skill areas stressed in the clinical setting are communication skills and political skills.
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The Ohio State University

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FOREWORD

The typical career patterns of school administrators are somewhat unique among all professionals. Graduation from college precedes starting as a teacher and possibly as an administrator for several years prior to seeking advanced degrees, special certification, or other intensive professional growth experiences.

This Bulletin examines some of the mid-career options for school administrators. It compares these options and raises questions regarding some problems associated with mid-career study.

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Kenneth A. Erickson
Executive Secretary
Oregon School Study Council

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MID-CAREER STUDY FOR SCHOOL ADMINISTRATORS: PROGRAMS AND PROBLEMS

Introduction

An enormous investment of dollars and energy is being made in staff development, mid-career and otherwise. Estimates of the nation's total expenditure for staff development in education run into billions of dollars. Leaders in educational institutions need to examine carefully the quality and the productivity of that investment. There is reason to believe that much of what is done in the name of staff development, inservice training, or continuing professional education is less than effective.

Staff development, including mid-career education, is highlighted at every turn in the road. Local school districts are establishing programs, professional associations have several mechanisms in place, universities are stepping up their efforts and are much more innovative than in the past, state departments of education are designing their own ways of improving human performance, special agencies are being developed by professional groups (such as the National Academy of School Executives), local academies for staff development are cropping up here and there, and teaching improvement centers are being established. One could cite numerous other examples.

The private sector, too, has its display of learning opportunities. The American Management Association, The School Management Institute in Ohio, The International Graduate School of Education out of Cherry Creek, Colorado, are examples. Foundations, too, are in this business. The Kettering Foundation and the Ford Foundation are two that are well known. Rockefeller and Carnegie have invested in intern programs, and other smaller foundations are alert to this need as well. All in all there is a cacophony of staff development sounds. And there is a broadly differentiated set of institutions, agencies, businesses, and governments involved in the staff development business.

Despite these efforts (most of them marked with good intentions and nobility), we're still falling far short of elevating the level of human performance so that it is equivalent to demands and needs of our time. There are probably several reasons why this is the case. One reason is that many staff development programs are designed upon improper bases or assumptions. Others are unrealistic in other terms. This Bulletin looks at some of those assumptions, examines some of the existing formats, and suggests ways to heighten the value of our investment in staff development, particularly at mid-career.

Education at Mid-Career

Several attempts have been made to provide sound opportunities for practicing administrators to have extended learning opportunities at mid-career. There are reasons why we have thought it important to allocate time and resources for improving our capacity to perform. Some of these grow out of the feeling that many practitioners need relief and rehabilitation. Others feel that they need a chance to "recharge their batteries," to "get away from it all" for awhile, to put their feet up and think about their problems. Others sense that there are areas of knowledge and skill development which need attention in their own regard.

School districts which are reasonably enlightened recognize the significance of this need and have provided either programs of their own or systems of support which allow people to engage in a rich variety of self-development activities.

At The Ohio State University we have had substantial experience with two mid-career program formats. One of these is for practicing administrators, many of whom have been principals. The other is The National Program for Educational Leadership which has involved the Department of Education in North Carolina and six major universities. As a result of our work with these two programs we have learned about problems and issues in mid-career education. We have witnessed the

questions which arise when persons successful in another profession or occupation shift over into education. We have witnessed, as well, the problems and issues which are associated with leaving one's job for six months or two years, moving into a campus setting, adjusting to that new environment, then experiencing the anticipations that go along with re-entry into the job situation.

Both the mid-career program for practicing administrators and the NPEL program have encountered a common problem: It is often difficult for intense, busy, harried executives, whether they be from education or some other field, to suddenly find themselves in an environment where many opportunities for self-development are available but little counseling or direction exists for that self-development. It has been our philosophy at Ohio State that each individual should be substantially in command of his own staff development programming. Thus, when people arrive, they are given many learning and skill development options, some counseling in regard to those options, but the responsibility for final choices resides essentially with the person at mid-career.

Some people can handle this freedom well. Others stumble, make false starts, and misuse substantial amounts of their time. This seems to be true of other programs, especially of intern programs. The Washington Internships in Education, The Rockefeller Fellowship Programs, the several leadership training institutes sponsored by the Office of

Education, The Consortium Fellowship Program financed by the Ford Foundation--each of these has program participants who have encountered trauma associated with program entry, program exit, and job re-entry.

Clinicianship

One of the first learnings that has grown out of work at Ohio State is that, whatever our program, it must deal fundamentally with the problem of acquiring knowledge and utilizing it--or, bridging the gap between theory and practice. We have discovered, much to our chagrin, that possessing knowledge is in itself insufficient. People need to know how to apply their knowledge. We have proceeded in the past on the improper assumption that, if we know something, we can act on the basis of that information, data, or knowledge. But this is generally not the case. There are many skills which we need to refine if our knowledge possessions can be effectively translated into knowledge applications.

Clinical education, as I define it, is the process of learning in field settings where the sustaining emphasis is knowledge application, feedback, appraisal, and reapplication directly to affect improvements in human performance. Several references will be made to experience at The Ohio State University with two programs involving persons at mid-career. One of these is the National Program for Educational

Leadership (NPEL) supported by the U. S. Office of Education; the other is the Mid-Career Program in Educational Administration supported by the Ford Foundation.

NPEL Fellows were (and are) non-educators with interests in educational leadership. The Mid-Career Program in Educational Administration, on the other hand, is for seasoned administrators. Mid-Career Program participants are chosen, most often, from principals or assistant principals and occasionally from the ranks of assistant and associate superintendents--for six months of campus-based, mid-career education. Field experience is an important part of NPEL; field experience has been much less central-stage, until recently, in the Mid-Career Program in Educational Administration. Clinical experiences were rare in both.

Over the past several years the profession of education has adopted words like "clinic," "clinical experience," and, more recently, "clinicianship." The utilization of terms from the medical lexicon is a mixed blessing. Those terms do communicate the practicality of learning in real settings, and thus we have found ourselves using them over and over again in our work at Ohio State. (We are searching for more appropriate language to carry our meaning regarding improved ways to bring knowledge to bear upon education or training in field settings.) Clinics, in medical usage, are places where diagnostic and prescriptive activities occur. They can be "set up" for the patients to come to--or they may on rare

occasions go to the patients. Health clinics are locations for the application of knowledge to human health problems. Usually clinical services are applied to individuals. Indeed, people from all over the world seek the services of certain clinics. The Mayo Clinic in Rochester, Minnesota, is one example. The Menninger Clinic in Topeka, Kansas, is another. At these and others like them, advanced systems for knowledge retrieval and application are clustered. The clinic's service includes a diagnosis, prescription, application, feedback, re-diagnosis if necessary, adjusted prescription, application, and feedback. Each decision point is also a knowledge application point.

There are no absolute counterparts to these clinics in education, either for individuals or institutions. We cannot physically move an institution, e.g., a junior high school, into a social science Mayo Clinic. We can more easily move our social science understandings into the field. We can diagnose, prescribe, apply, and respond to feedback. We can collect and store information in one setting that may have value to others in similar circumstances. And we can simultaneously blend diagnostic and prescriptive activities with the preparation of a variety of professionals, especially prospective administrators and policy scientists.

A Commentary on Experience

As a prelude, I would like to describe briefly one set of clinical experiences which involved five NPEL Fellows and myself. The setting was Detroit. The professional responsibilities were a part of our work with the Detroit Education Task Force--a citizens' group engaging in a new form of public problem-solving. The clinical activity involved a serious attempt at peer criticism, observation, debriefing, role playing, and reappraisal.

The Detroit experience, for me and for the five NPEL Fellows, was a clinical experience. The NPEL Fellows through their work in Detroit, became involved with an exceedingly diverse assembly of laymen interested in education. They also came to know and work with a wide range of public school officials, principally administrators and staff members of the Detroit Central Board of Education. We lived in the city during much of 1973-1974, and had an opportunity to learn, firsthand, of the richness and intensity of Detroit urban life.

As an administrator of the National Program for Educational Leadership, as well as the principal staff officer for the Education Task Force, it was my responsibility to blend the learning expectations for Fellows in NPEL with the staff needs of the Education Task Force. We were doers and learners, simultaneously. For each of us our responsibilities

were marked by diversity as well as excitement. The experiences were at once intellectual and visceral. We came to know the problems and issues confronting the Detroit Public Schools, but we also discovered our own strengths and weaknesses (personal and professional) as a consequence of our encounter with those issues and problems.

The six of us designed and participated in a "learnings" seminar during the year. For several hours each week, usually on Thursday evenings, we focused the seminar on problems before the Task Force and on our own individual Task Force responsibilities. Over time, we developed our capacities to deal clinically with the issues of education as well as our own performance and behavior. The seminar was used as a mechanism for personal criticism and for assessing our learning. When one of us had a major responsibility with the Task Force, especially one that involved public performance, we tried to anticipate reactions to our performance as effectively as we could. We went over written materials thoroughly. We debriefed immediately after public presentation, and located those aspects of our behavior that warranted special attention. Similarly, we reanalyzed the substance of written materials and tried to improve them when they came up for subsequent presentation and review. The work (and learning) setting allowed enough free time for detailed professional and, on occasion, personal criticism.

In my judgment, the seminar was of unusual value. I can speak on the basis of my own experience and my own estimate of its meaning for me. And I believe that my sentiments are those of the NPEL persons there. Preparation for leadership will be incomplete until we insist that field-based learning situations meet two criteria: (1) the setting allows for the assumption of solid, fully developed responsibilities with accountability spelled out; and (2) the location is congenial to developing strength among the members of a specially designed collegial learning community, where the bases for criticizing the performance of the persons in this collegial community are clear.

The words "clinic" or "clinical" are used much too freely. The terms are applied to a range of experiences. Often they are used as synonyms for internship or field experience. A clinical experience in a training sense must include close observation of human performance, judgments about that performance, and prescriptions relative to its improvement. It is sustained through application of knowledge brought to the clinical setting. The clinical experience should involve a clinician and a learner, or a set of clinicians and a set of learners who have rather clear differentiations in their roles, but who associate essentially as learning colleagues. Clinicians are both diagnosticians and prescribers. Clinicians and learners are tied together by a common devotion to problem solving.

To realize the difference between clinical settings and internship or field experience settings is essential in understanding the difference between the clinical experience and the field or intern experience. Normally, an intern is guided in his learning development through field supervision and training center supervision. The supervisor "watches" the intern more than participates with him as done in the clinical experience. Usually, a setting for the internship is located, a field supervisor is identified and named, a time frame for the experience is determined, and the supervision of a learning program sponsor is specified. Sometimes the internship and/or field experience is observational on the part of the learner. Sponsoring agency supervisors and field supervisors, as well as persons in training, find this broad observational experience useful. Increasingly, intern and/or field experiences include more "hands-on" responsibility. Settings are located where in-depth responsibility is possible, which stands in sharp contrast to what were essentially observational locations in the past. In most cases, however, learning outcomes fall short of those expected in a genuinely clinical environment. In the clinical setting, the "supervisors" are sharing more intensely the learning experience with the learners; knowledge, theory and practice are more closely knit; and the clinics are designed around the needs of the learning participants, whereas in an

internship, the field setting determines to a greater extent the experience of the learners.

Observations About Skill Development

A clinical setting should be rich in practice options. The clinical supervisory and instructional team should be gifted in utilizing observational and feedback techniques. The clinical learning group, i.e., students, sponsoring agency supervisors, and field supervisors, should join in the selection of skills to be developed, as well as the cognitive areas to be strengthened. (Those choices should be made after a reasonable period of work in the field.) A range of clinical staff field observations could be designed which would permit the identification of those skills as well as cognitive areas to be developed.

Two essential skill areas to be used in a clinical setting are reviewed briefly in the pages that follow.

Communication Skills

It is reasonable to expect that most persons at mid-career (as well as those who may be entering preparation) will bring to a clinical setting substantial skills in communication--at least in the area in which they worked. It is reasonable to expect that a person can write clearly and concisely. It is reasonable to expect that a person can speak with clarity and convey meaning accurately. It is not

reasonable, however, to expect each person in training to bring the sensitivity, flexibility, and dexterity required of the variety of communication demands that are embedded in many settings--some with which he has not had much contact. Campus-nurtured and developed skills may wilt and fade in the face of field requirements. Therefore, it is right and proper to expect the clinical setting to provide practice options that will allow the development of new communication capacities. Clinical teams should include persons with talents sufficient to pass judgment upon the effectiveness of communication behaviors, as well as to prescribe the use of the best appropriate knowledge available.

If a mid-career person in a clinical setting is required to write a position paper or some other substantive document, the paper should be subjected to critical analyses which transcend those normally available. Criticisms should be provided by a range of observers, in many cases including persons beyond the boundaries of the formal clinical learning team. In settings marked by socio-economic, racial and ethnic diversity, criticism should be sought from persons who reflect that diversity. Both written and oral forms of communication should be placed under such scrutiny.

Listening skills are as important as speaking or writing. In highly charged settings, or even in those that are less volatile, quick word exchanges lead to responses that

are often poorly informed. Leaders must be skillful listeners and sorters. They must be patient to hear others out. They must sift and sort with dexterity. They should, in many situations, employ playback techniques to those who have issued statements, or soliloquies to them. They should, as we all know, look beyond content. The leaders should also be able to analyze communication of which they are not a part and garner insights through these observations.

Most of today's leadership settings, particularly those inhabited by school superintendents, state commissioners of education, federal officials, university presidents, and other highly visible administrative figures--are in the public eye. Persons who occupy those posts are confronted frequently by television and radio reporters. Following board meetings or other public events, or even the sanctity of an office, microphones and cameras are thrust in the faces of leaders. They are asked to respond to questions with little or no opportunity for preparation. A clinical setting should provide opportunities to test learner capacities to respond in such situations. If the clinical settings do not contain these skill-training options, then simulations should be designed so that those communication skills can be appraised and strengthened. The clinical team, through simulation, could record behavior, make judgments about it, feed back those observations, redo the simulation, and engage in a definitive skill development exercise.

Skills are needed in working with radio and television personnel, obviously, but leader relationships with newspaper reporters are equally important. There are skills that sharpen a leader's capacity to work with the press. For example, the use of precise terms, recognizing the affective properties of what is said, brevity as distinct from wordiness, optimism as distinct from despair, generalizations as distinct from particulars, directness rather than evasiveness, and choosing language for heterogeneous rather than homogeneous audiences. When leaders use poor words under the interrogation of the press, especially in settings marked by diversity, this should be pointed out to them. When they are not providing enough detail to support their meaning, that too, should be spelled out.

Feedback has become a household word. It is an important term. Certainly in regard to the behavior of people in training, there should be sustained and repetitive observation of performance, and sustained and repetitive forms of feedback. Communication skills should become almost second nature, a part of the person, and should improve markedly over what they were as individuals enter into a clinical learning environment. And the collegial fabric (of learners and teachers) should be tough enough to support harsh criticism in relation to skill development.

Political Skills

Leadership, administrative, or managerial positions require more and more sophistication in the political skill areas. Although positions may vary in terms of the degree of skill refinement required, the need for such skills is increasingly recognizable across most leadership settings. Several questions are worth noting: What are the central, most effective political skills that leaders should possess? How can political skills be assessed? What sorts of clinical settings allow political behaviors to be displayed so that judgments can be made about them? What clinical staff capacities are required to "apply" knowledge of political behavior so that it is reflected in leader behavior?

Each of us is called upon frequently for judgments about others. If we were asked about how well persons for whom we work understand political behavior and how effectively people behave politically, how would we respond? How do persons mobilize others? Do they diagnose? Are they persuasive? Are they gifted in influencing? What mannerisms and actions characterize their persuasive behavior? How adroit are they at moving into vacuums? What bases do they employ for initiating activities? How carefully and upon what bases do individuals choose to be involved in a mobilization? To what extent is the leader willing to share leadership? How gifted is the person in sustaining an activity? Does the individual lead a set of events to culmination? Is the leader willing

to abort along the way? To endure pain in the process? Can the individual clean up the wounded after skirmishes? Is the individual willing to patch and paste a situation together in order to fight another day?

It is easy to list questions. It is much more difficult to locate answers. I would argue that few persons responsible for preparation programs raise such questions nor do many attempt to respond to them programmatically.

Collegiality and Learning to Lead

A field learning opportunity should be based upon the simple assumption that everyone is a learner. A collegial association must be based upon the genuine sharing of abilities. The field supervisor knows things that a sponsoring agency person does not know. Similarly, a sponsoring agency team member knows or has access to data unavailable to the field supervisor. Learners bring to the situation substantial amounts of information themselves and in many cases highly developed skills. At times learners' skills exceed the skills of those responsible for constructing and supporting the learner in the field. The ideal collegial community will produce a powerful learning atmosphere.

A clinical setting saturated with problem-solving opportunities allows the pursuit of two virtues simultaneously. First, if the learners are problem solvers, then solving

problems is an asset to the setting as a whole, i.e., clinical leaders and others participating benefit from the problem-solving activity of the learners. Second, involvement in problem solving is extremely educative in its own right for the problem solvers themselves. Thus the clinical situation for learning should be marked by high responsibility for problem solving and high accountability, but with sufficient flexibility to permit introspection, self-reflection, and collegial appraisal of performance.

There should be time for instant replay, for detailed feedback, for informed interpretation, for dialogue and conversations about behaviors. The climate should be open for criticisms to flow among members of the collegial team. Learners should "have their day in the sun" with opportunities to pass judgment upon the performance of those who have responsibility for their own learning.

For learners in clinical settings who are from education there is a particular phenomenon at work. Most who move into educational leadership posts are former teachers. That past experience has both positive and negative attributes. One of the most severe negative features is that the teacher psyche must be adjusted so that it can become a learner psyche. Former teachers who become administrators come to the administrative job with chalk in their hands. They find it very difficult to jettison the teacher image, the teacher expectation, the teacher behavior and assume the attributes of the

flip side. Ironically as it may seem, it is difficult for teachers to become learners right away. It rarely is an automatic adjustment. Teachers must learn to become learners.

Of course the learners in clinical settings cannot be under human observation all the time. Choices have to be made regarding critical events which display skills and attributes. Persons experienced in supervising clinical education will learn to identify occasions which permit a "natural" opportunity to observe leadership talent and ability. Thus, the points for observation should be chosen judiciously with a view towards displaying a range of leader attributes rather than a single attribute. There are times when only a single talent can be appraised, but more often a panoply of abilities will be in view.

Techniques for recording observations should be employed. Tapes, both audio and video, are typical possibilities. There are others that call for skilled note taking. In fact, persons in training should employ their own devices for making observations about their learnings. Diaries, if considered thoughtfully, are helpful.

The clinical situation yields well to debriefing techniques. Debriefing is, itself, a skill that leaders should possess and can occur in one-to-one situations or in small groups. If more than one learner is in a particular field setting, then groups of learners, through seminars or

debriefing sessions can benefit from group debriefing approaches. Groups of learners can develop confidence in using debriefing techniques independent of clinical staff. Disciplined debriefings, conducted within appropriate guidelines and ground rules, are substantial learning tools.

Prior to the contemporary concern about privacy and its protection, administrators often were called upon to write recommendations about people which were used in employment decisions. (The future of that practice may now be in doubt.) Such recommendations were expected to be reliable summaries of what one human being knew about another. Letters of recommendation or statements in placement papers were usually general, and lacked specific situational references which would allow a reader to be informed definitively about a range and quality of human performances; they did not deal with specific talents and abilities, and were usually strength-oriented rather than weakness-oriented. Few letters of recommendation, or statements in placement papers, contain hard data, as it were, upon which employers can build dependable judgments, especially about rather narrowly defined abilities and capacities. For example, an important leader attribute is the capacity to understand "hidden agendas," respond to them, and reflect a pattern of behaviors which is constructed in their regard. The presence or absence of that attribute, particularly in settings marked by complexity, is critical to leader performance. The clinical

setting should allow for judgments to be made about that skill. (Similarly, as stated earlier, there should be recording processes which allow an individual to have a self-estimate of his capacities.) And if data are needed in the future to support employment decisions, the clinicians can provide extensive and definitive data about performance.

The Design of a Clinical Education Team

There are few clinical education models in existence. There are examples of experience programs where various existing positions are used to support the learner in the field. But few of these have been as fully designed and implemented as could be for maximum benefit--as a clinical setting might give.

There are several theoretical designs that could be considered. One is to design around people, possibly generalists, who know a lot about the skill and knowledge areas related to leadership. Three or four member clinician groups could assume responsibilities for several learners in one or more clinical settings. The assumption would be that these clinicians would possess talents and attributes sufficient to meet a rather fully developed set of learner needs. A second design could include a core clinical team with a narrower display of specializations. To extend the team's

capacity, other resources could be added to meet special learner needs. Resource people could be named as auxiliary members, or panels could be convened for special purposes related to skill development and knowledge assessment.

Considerable work should be devoted to designing and testing clinical teams. Key to the formation of clinical groups is the basic understanding that the groups are instruments for bridging the gap between knowledge and practice. They are intelligence and information conduits leading to improved leader performance. And clinicians need several skills to keep the learning atmosphere highly motivated, primarily the skill in brokering knowledge and information.

Earlier references were made to communication and political skills. Certainly clinicians working in the field would have to have access in information and knowledge related to those skill and knowledge areas. The brokerage, bridger, translator, conduit functions are each unique functions, yet highly related to one another. And those who choose to design clinical teams should keep these functions uppermost in their thoughts as they engage in the architecture of clinical education.

Concluding Thoughts

Our Mid-Career Program for Educational Administrators at The Ohio State University has enrolled more than thirty persons

at mid-career. Evaluation of the program has revealed support of the campus-based setting and the learning options available. Evaluations of the setting and the learning options showed a substantial imbalance between "experience" and "theory" or "knowledge." The mid-career persons are experienced in the extreme, but they are devoid of theory, schemes or analysis, concepts, or frameworks as tools for understanding and profiting from their experiences. Campus-based preservice programs err in the other direction. It is necessary that a constructive balance be achieved. But in striking that balance, new clinical capacities will have to be employed if we are to bridge, genuinely, the theory/practice gap.

From time to time I have had direct or indirect responsibility for field experience and/or internship phases of conventional preservice preparation and, more recently, the experimental National Program for Educational Leadership. In each case, at the University of Chicago, at the University of Minnesota, and more recently, at The Ohio State University, institutional intentions were noble. However, at each institution we fell far short of what was required to be effective in clinical education terms. It is not attractive in these times to remark about scarce or ineffectively applied resources. But it is true that we have invested marginally in the clinical and/or field experience phases of pre- and in-service preparation. It is done with the left hand. It is

an afterthought.

We should be straightforward about the resource demands of clinical forms of education. If we are to do the job, smaller numbers will have to be served by larger and more complex assortments of talent and resources. Leadership needs are so apparent in contemporary society that we should deal seriously with the resource problem relative to leadership education. Society's investment in leadership development has been modest, indeed. It may be that now is precisely the time to do the design work in preparation for a larger future investment in leadership development.